ORAL HISTORY PROJECT

Orvar
Swenson, MD

Interviewed by
James W. Kendig, MD

January 22, 2003
Charleston, South Carolina

This interview was supported by a donation from Children’s Memorial Hospital, Chicago
PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

James W. Kendig, MD

Dr. James Willis Kendig received his MD degree from the Jefferson Medical College in 1970. He completed a fellowship in neonatal-perinatal medicine at the Milton Hershey Medical Center of the Penn State University. Between 1982 and 1999, he served on the faculty at the University of Rochester School of Medicine and Dentistry. In 1999, Dr. Kendig returned to Pennsylvania and is now a professor of pediatrics in the Division of Newborn Medicine at the Penn State Children’s Hospital and the Penn State College of Medicine in Hershey.
Interview of Orvar Swenson, MD

DR. KENDIG: This is Dr. James Kendig. I’m in Charleston, South Carolina this morning to interview Dr. Orvar Swenson for the American Academy of Pediatrics and the Section on Surgery. Dr. Swenson you have had a long and most distinguished career. Could tell me about your life and some of the developments that you have accomplished and witnessed in the field of pediatric surgery?

DR. SWENSON: Well, as you know I was born in Sweden. My family decided to embark on a new life in the United States. My father had traveled in the United States as a young man and was very much impressed. I understand that one of his objects in moving was to give his two sons a good education. That was impossible in Sweden at that time unless you were of the higher class or had a great deal of money. So we emigrated to the United States when I was six and settled in Independence, Missouri. My father had some connection with the Mormon Church and that’s why he chose that area, I guess.

At any rate I went to school there. I can’t explain why, but I started to work very early. The only reason I can give you is that I remember my father taking me to buy clothes and shoes. I saw a pair of shoes that I would have loved to have had, but they were too expensive, I guess. My father selected something substantial and not stylish and, of course, I never dreamed of voicing my opinion. So we got the shoes that he wanted and I didn’t really like. I thought about it and said to myself, “Well, why not make money and then you can buy any doggone kind of shoes you want?” And so my brother, who is two years older than me, and I talked about it and we agreed to get a paper route; but that wasn’t very good pay. So we scouted around and found a little factory that made electrical switch boxes. You could work there and assemble one of the boxes for one cent. If you packed a carton of a hundred, you made a dollar. If we worked after school, we could make a dollar, and if we worked on Saturday, we’d make another dollar. From that point on, my brother and I were no expense to my family as far as clothes and shoes. Well, that job didn’t suit us because the owner was always short of money. He sometimes was two or three weeks late in paying us.

I was active in the Boy Scouts, which was a very fortunate thing because I lost my mother early. Our patrol leader, Dudley Smith, became a very important person in our lives. He was an expert in making a fire by friction and, in fact was said to have established a world record. People began saying, “Well, we have got to buy fire making kits from Dudley,” and he built up little business and made some money. His father was a Mormon minister and often financially strapped, so this came in very handy.
When his business had developed quite a way, he graduated from high school and decided to go to the University of Southern California. He said to us, “Boys, I’ll sell my business to you” and we made an arrangement to pay him 10% of our profits. When we took over the business, we moved it to our house. At first, we didn’t have much equipment. We bought a band saw and to power it we rigged up my father’s Ford Roadster. We jacked up the rear wheels, made a pulley that we strapped to the wheel. When we started the motor we could saw a lot of wood. Then we moved our equipment into the basement. How our parents tolerated the noise I don’t know, but we put a long drive shaft in with a big motor and we had band saws and circle saws and edge joiners. We produced a lot of fire making kits.

We did quite a business, because the national Boy Scout organization bought our kits by the hundreds. By the time I went to high school, we needed more space and so my brother and I bought a piece of land that was down on the railroad track and had a siding. I asked my father for a loan of $500, the only time I ever asked him for money. We built a shop on the lot when I was a freshman. The fire making kit business didn’t make much money, so pretty soon we started making archery equipment. Here’s one of the catalogs, a picture of our original building and a picture of my brother. He was a big fellow, taller than me.

DR. KENDIG: You made the arrows and the bows and things like that?

DR. SWENSON: Oh yes, I can show you some of the stuff. Anyway, it grew into a nice business and we added two more buildings and hired three or four high school kids. I was the salesman. I used to go to New York to sell our products to Abercrombie & Fitch and other supply houses. The reason that we did well in the archery business, was because at that time all the archery equipment was imported from England and it was all hand-made. Beautiful stuff but very high priced. We figured we could devise ways to put out a product about as good as theirs at half the cost. We had to have a special kind of wood that only grew in Cuba. So I went to Cuba and had an appointment with the Secretary of Agriculture down there. He was really surprised when this high school kid walked into his office, but anyway, we arranged it so we could ship our special wood in directly

I went to college at William Jewell College in Liberty, Missouri which is just across the river from Independence, so I could still look after the business. We had just about decided that I would go to law school and my brother would go to the Wharton Business School in Philadelphia. However, it was just at this time that our directions changed. Our old scout leader and business partner Dudley Smith, who was then a student at Harvard Medical School, told us that we should go into medicine. In college I got very interested in biology and I liked it very much. I visited Dudley at Harvard Medical School when I was back east on my sales trips, and boy, I was
impressed! So, all of a sudden my brother and I decided we’d go to medical school. He had to go back to college for two years to take the required subjects. I still had two years of college to go, so I was able to arrange the courses.

In my senior year we applied to various schools. My brother was accepted into Harvard right away but I was placed on the alternate list. When I hadn’t heard from Harvard school by late in the spring, I called my brother and said, “Gee, what should I do? I’m just in a dither.” He said that he would write to Dean [Worth] Hale, whom he’d met, and tell him our problem. “We’re a couple of poor boys who want to go to same school to save money.” Dean Hale must have had a good sense of humor. He wrote back a short letter, “Bring your little brother.” So that’s how I got into medical school. Of course, our business was growing and we had hired a manager. We could afford to go to medical school because we were making pretty good money.

I was no stellar student in medical school. I always had the worry and details of our business in the background, and we were totally dependent on it since our father had died. We had no money and we had been on our own since we were in high school. This isn’t an excuse for why I was only an average student in medical school; I just wasn’t the smartest of the guys. At Harvard they emphasized the importance of research and investigation which was right down my alley. I wanted to understand and fix things. So medical school was a very fine experience for me, and I graduated in 1937.

DR. KENDIG: Well, your work in woodworking was a good training for a future surgeon. Certainly it helped develop dexterity.

DR. SWENSON: I wanted a straight surgical internship but there weren’t too many available. I would have loved to stay in Boston, but the Boston hospitals actually selected their interns very early. Although it was supposed to be an open system, if you hadn’t been invited, you had no chance, and I wasn’t invited.

So instead I went to the Ohio State University Hospital in Columbus. Shortly after I began my internship, I became ill and had joint pains and a high temperature. I tried to work but could hardly make it. I was put in the hospital and diagnosed with acute rheumatic fever. I spent the next six months in bed.

When I finally, I got out of the hospital, I worked with Dr. C. M. Curtis, who was chief of surgery. He was an unusual surgeon who also did investigative work. He was interested in the effect of morphine on the gastrointestinal tract. My part in his research project was to be the “scut boy.” I mostly set up the recording equipment, but it was great fun. I talked to a very nice
urologist who said, “Swenson, you’ve lost this year. If you stay here, you’ll have to go through another internship. I’ve got friends at the Peter Bent Brigham Hospital in Boston, and I’ll do everything I can to get you in there if you will work with me on some research projects and do a good job.” So I worked with him and he did recommend me to his friends at the Brigham. They required an examination and I went to Boston and took them. After the exam I said to myself, “Heck, I flubbed it.” But they took six guys and I got the tail end. However, I had a ten-month period to spend before I could begin as a surgical house officer on the combined Peter Bent Brigham/Children’s Hospital [Boston] service. I met Dr. Sidney Farber, head of pathology at Children’s. He said, “Come work with me,” and so I spent almost a year as a house officer with him in pathology and doing autopsies.

DR. KENDIG: What a great opportunity.

DR. SWENSON: Yes, it was a great opportunity. Then I began my surgical residency at the Brigham. I won’t bore you with the Brigham system and schedule. It was brutal; no nights off, but anyway I got through the next three years. I decided that wanted to go into academic medicine and do investigative work. They had the old Halsted system of surgical residency. It wasn’t a parallel system; it was pyramid. They took a large group of interns and then a smaller number of assistant residents, and only one guy was chosen to be chief resident at the top. Dr. George D. Cutler who was chief of surgery at the Brigham said, “If you go through the assistant resident level training in my program, you’re a good surgeon. You’re safe to go into surgical practice.” He always reserved the top jobs for people who wanted to go into academic medicine and you could hold them as long as you wanted to. There was no limit, except that the guy behind you was always jabbing you to get out.

Then in 1941, Dr. Cutler gave me the Arthur Tracy Cabot Fellowship. For two years I worked in a Harvard research laboratory, a wonderful experience. We did some interesting things. I worked with a Canadian surgeon, Dr. [Mercier] Fauteux who was very interested in angina and the causes of angina. He believed that death after an occlusive heart attack was due to cardiac fibrillation and he believed that if the coronary arteries were denervated this could be prevented. We studied a number of dogs. When we occluded a coronary artery, they went into fibrillation. We then dissected the coronary branches where they join together, and treated this area with a very strong solution of carbolic acid to destroy all the nerve structures. When we occluded them again, they didn’t fibrillate.

Then we got interested in fractures and nonunion of fractures that were hard to do anything about, so I thought we would study fracture healing. I wanted to do pH studies of the hematoma at the fracture site. The problem was that we couldn’t get enough blood to do pH studies, which required two or three
cc’s of blood. I ran into a resident who had devised a system requiring only a small amount of blood, so we were able to do pHs.

After about a year and a half, World War II had started. I joined the Harvard Medical Unit, but they threw me out because of my history of rheumatic fever. So I went back into the clinical surgical services and finished my training as the chief surgical resident at the Brigham in 1945. I enjoyed my year as chief resident very much.

Then I got a call from Dr. [William Edward] Ladd who was chief of surgery at Children’s to come and see him. God, I was overwhelmed. I knew Dr. Ladd. I’d been on his service as an intern, but I was sure that he didn’t remember me. When I went to meet him, he offered me a job to set up a surgical research lab at the Children’s Hospital, and that’s how I got started. Now, that’s a long-winded story. What else can I tell you?

DR. KENDIG: Well, that’s perfect.

DR. SWENSON: Well, I enjoyed my research work but I also had an appointment as an attending surgeon at the Children’s and at the Brigham. Four months of the year I had to supervise the inpatient service at the Brigham. In those days, of the 350 total surgical beds at the Brigham, how many do you think were private beds?

DR. KENDIG: Thirty-five?

DR. SWENSON: A little bit better than that—40. All the rest were ward patients cared for by the surgical housestaff and attendings. Children’s had only thirty private surgical beds and all the rest were ward. So they were great places to work. At Children’s, Dr. Ladd was chief of surgery. He was a very conservative surgeon, but he did all sorts of things. He worked on malformations and really made some sense out of how they might be corrected. And at Children’s there was also Dr. Bob [Robert Edward] Gross who played an important role in my life, as you’ll see. He was famous for doing the first surgical ligation of a patent ductus arteriosus. However he did that surgery when he was still a resident, and he purposely did it when Dr. Ladd was out of town on vacation. Dr. Ladd always took a two month summer vacation at a ranch out in Wyoming. Well, I don’t know how much that upset Ladd, but when I came to Children’s, it was common knowledge that those two guys weren’t on speaking terms although they would say hello to each other on rounds. I have to say that in my work and contacts with both of them; I never heard them criticize each other.

We all felt that Bob was going to get the appointment as chief of surgery at Children’s when Dr. Ladd retired. Bob was my chief resident when I was an resident at the Brigham and one day he said to me, “I’m going down to
Baltimore. [Alfred] Blalock wants to offer me a job there. How would you like to live in Baltimore?” And I replied, “Look, anyplace I land is great.” I was quite flattered that Bob went that far. He never was a very talkative guy and didn’t have many friends. When he came back he told me, “Oh, the job was no good,” and I was terribly disappointed.

When Dr. Ladd offered me the job to set up a surgical research laboratory, I told him I’d think it over. He said, “Okay, let me know in a few days.” I called Bob up and said, “I’d like to talk to you.” He invited me out to his house for dinner, and when I told him about Dr. Ladd’s offer, it was quite a surprise to him and, but he finally he said, “I think it’s a good opportunity; you should take it.” But my wife Melva [Swenson] and I were a little uncertain about whether we really had Bob’s full support.

One thing that I really got interested in at Children’s was a group of kids with megacolon. There was no treatment and they were dying. I talked to Dr. Ladd and asked him, “What can we do for these kids?” He told me that the Mayo Clinic had published a paper saying you could cure them by taking out their big dilated colon, but that it doesn’t work. He gave me some cases in which this had been done and when I looked up their records the results were miserable. Another idea was to treat megacolon with a drug, methylbromide. A number of published articles said it was great; but it really it didn’t work. A number of surgeons tried cutting parts of the autonomic nerves that enervate the distal part of the colon. You’d be surprised, hundreds of these operations were done and their results were published quickly. Then, with passing time, surgeons, including Dr. Ladd, began saying, “Absolutely, it does not work. I’ve done it and it doesn’t work.”

Well, I got very interested in these children with megacolon, particularly one little boy who was very sick, and he was on the medical service. Do you remember Dr. Charlie [Charles A.] Janeway? Well, Charlie was a friend of mine. He was a junior attending in internal medicine at the Brigham when I was a senior surgical resident. He became a pediatrician, and later chief at the Children’s Hospital by just saying, “I am a pediatrician!” Well, anyway, this child was on the medical service and was being treated for some kind of a malabsorption. They couldn’t make much out of the case, but they wanted him to be proctoscoped to see if he had inflammatory bowel disease. When he was proctoscoped, they found mucosa of the rectosigmoid colon that looked peculiar. At that time, Dr. Ladd had treated cases of ulcerative colitis in children with a colostomy and although he only had a few cases, they did pretty darn well. So he told me, “Okay, this boy needs a colostomy.” Well, the next morning after surgery, this kid, whose abdomen had been blown up like a balloon for years, was absolutely flat—like a balloon that had been pricked. His colostomy was pouring out large amounts of fecal material.
This kid did beautifully. I thought that he must have had a mechanical obstruction which we couldn’t see on proctoscopy.

I had been interested in intestinal peristalsis starting with my time with Dr. Curtis at Ohio State and studied esophageal activity when I was the Arthur Tracy Cabot Fellow. So, I immediately thought, “Well, this colostomy can give me an opportunity to do peristaltic studies on this patient.” I got all set up to measure peristalsis through the colostomy. I recorded first from the proximal side, and I couldn’t believe my eyes. He had beautiful peristalsis. I thought that I was going to find that he had no peristalsis and it was, at first, a great disappointment to me. Then I began thinking about it and I knew that we had to do the other side, the distal side. And when we measured this, there was no peristalsis. I went to people in the department of physiology for answers and they said, “There’s probably a good reason for no peristalsis in the distal loop. Maybe the colostomy has disarranged things.” They also pointed out that it might be normal not to have activity in that part, so they wouldn’t accept my recording of the distal part. This hampered me a little bit, but I then began to look at x-rays of the distal rectosigmoid with Dr. [Edward B. D.] Neuhauser, chief of pediatric radiology. Well, Ed let me go into the stacks and some med students helped me pull out a lot of old films from megacolon patients. These showed great big dilated loops of the ascending and transverse colon, but we couldn’t make out the distal part of the rectosigmoid colon. I went to Ed and he said, “Well, let’s outline it by putting a small amount of barium in the rectum. Lo and behold there was a narrow segment in the rectosigmoid that just ballooned out above. Now, there was nothing in the literature that I could find that anyone had ever done this kind of study in megacolon patients.

To get back to my patient who had had the colostomy. He had done beautifully but his family was sick of taking care of the colostomy and wanted to get rid of it. So Dr. Ladd had a consultation and Charlie Janeway, the professor came. Well, I was a junior member of the staff and I didn’t even get a chance to express my opinion. Charlie said, “Look I can take care of this. Close the colostomy, I’ll take him on my service and we’ll make him well.” So that was a great disappointment to me, but I watched him like a hawk and sure enough he was relapsing. Pretty soon he was constipated and his belly was as swollen as it had been before his colostomy.

So we did another colostomy, a transverse colostomy. I argued that the bowel at the colostomy was good, and had good peristalsis but if we dissected down, I knew we would have find a narrowing at the rectosigmoid. I decided we had to take that segment out and we worked out a surgical technique that could do just that. This idea drew a lot of criticism. People said, “You’re going to ruin these patients; they’ll have urinary incontinence; they’re going to have sexual problems.” But I argued that if we stayed right on the bowel wall and just skinned it out, that we could get by with this.
After the second colostomy, the child did well again. I saw him and talked to his mother during outpatient visits. I explained to her about my thoughts about removing the constricted part of his colon. Nothing could be guaranteed, but we might be right and hit the jackpot. She was a very nice lady and said, “Absolutely let’s go ahead.” And so I brought him in for the surgery.

In 1945, Dr. Ladd had formally retired but he still came to the hospital. Bob Gross was surgeon in chief and totally in charge. He never made rounds and had a huge private practice. The way he kept track of the service was by deciding who operated on whom. The chief resident saw Bob once a day and they made up the next day’s operating schedule. We all had the right to schedule patients, but they might be taken off or changed by Gross. He had complete control. Dr. Bob [J. Robert] Bowman was the chief resident when I listed my patient for the surgery. Bowman took the list to Gross, and then came back to me, with his jaw dropping open and said, “Gross is going to do that case.” I said, “What the heck is he going to do?” Bowman responded, “Well he wouldn’t say, but he’s going to figure out something.” There wasn’t anything I could do.

But they always had to call the parents to get consent for operation and the mother asked, “Who is going to operate?” When Bowman said, “Dr. Gross,” she said, “No, I won’t sign it. And I guess that hurt Bob’s feeling so he said, “Hell, we’ll let Swenson do it.” So I got to do it.

Fortunately, we didn’t have any immediate complications, but we didn’t know how we were going to come out in the longer run. We knew we didn’t hurt his urinary system because he could void. We had to wait a while to close the colostomy and he was one of the fortunate patients that didn’t have enterocolitis postoperatively. Everything just went smoothly.

After this, Bob’s attitude towards me completely turned around. I wasn’t able talk to him anymore and couldn’t get appointments to see him. Dr. [Alexander] Bill and I wrote this up a case report of our patient for publication that I wanted to submit to Surgery. Bob looked it over and said that it was all right, but we would have to change the title.” He said, “This is just a weird case; it’s not a real Hirschsprung’s disease.” So we had to change the title to a funny title – “Resection of the Rectum and Rectosigmoid with Preservation of the Sphincter for Benign Spastic Lesions Producing Megacolon.” But then he said, “I don’t want any more of these operations done until I’m sure that they will go right, so the operation was temporarily halted. But the medical service had a half a dozen kids, close to death, that needed to be taken care of and I think, somehow, pressure was exerted because, all of a sudden, word came through the chief resident that we could proceed again.
Early on in my work at Children’s we began to operate on younger patients with Hirschsprung’s. We did one young patient with megacolon, but could not find a distinct area of constriction so we didn’t know where to resect. When the kid did not respond, barium re-enema showed we’d left a constricted segment behind. Well, that gave me the idea of doing biopsies. When we entered into the bowel, we could tease off the mucosa and take a sliver of mucosa for examining under the microscope for the presence of ganglion cells. The barium enema wasn’t very accurate in very young patients or those with long lesions. I said to myself, “Why, hell, the thing to do is do a rectal biopsy!” I met Bob in the hall and told him that I was going to do rectal biopsies for diagnosis. He listened a minute and then he said, “Swenson, I forbid you to do this either on your own patients or on a ward patient in this hospital. You’ll end up with a lot of infection and trouble that I don’t want.” I listened to him, but later on when I got down to Floating [Hospital for Children], we did a bunch of adults patients. We did biopsies and we found that we could locate the area where there were ganglion cells.

Dr. [H. Edward] MacMahon, the professor of pathology at Tufts [-New England Medical Center] was a great guy. We published our data on the rectal biopsy the rectal biopsy and it remains a very good test today. But then things really changed for the worse. I got a letter from Bob that said, “If you co-author another paper with Dr. Ladd I will not reappoint you to the staff.” And I thought, “Damn, this is something.” I asked for an appointment with him to talk it over, but his secretary said, “He’s very busy, too busy to see you.” At Harvard at that time, they had a rule that you had to be promoted from one position to another within four years or leave. I was an instructor, the lowest faculty level, and I hoped to be appointed as assistant professor. I had published about 20 papers by then which was pretty good and there were no concerns about my clinical competence. Bob met me in the hall one day said, “I want you to know that I’m not putting you up for assistant professor,” which meant I would be out of the academia at Harvard. Well, my wife, Melva and I talked it over and she said, “Look, this guy wants you out; you’d better begin looking for a job.”

Although Bob rarely spoke to me directly, I would get notes under my door. My office was right across the hall from his. One note said, “I’m desperately in need of space. I have to take over your office, and I can’t give you an office in the hospital. You’ll have to go outside.” Well, my practice wasn’t very big, and it would be financially impossible for me to go into private practice, so I just didn’t know what to do. My secretary noticed that in my schedule I wasn’t having any private patients, which I was concerned about because I had bought a house, we had children. Although our archery business was still thriving, we needed to buy a whole new big setup and this meant that I had to arrange for a big loan to do this. So I was in a tight spot. Then my secretary said, “I just can’t get any of your patients admitted to the
“hospital.” I went down to the admitting office and I said, “Look, you turned down admissions of my patients, but I went on rounds today and there were several open beds.” “Oh,” they said, “Dr. Gross has all those beds taken and he’s got patients coming in.” Well a lot of them just stood empty.

With great reluctance that I knew I had to do something. I was on a committee of the Boston Surgical Society with the professor of surgery at Tufts University School of Medicine and he talked to me about their children’s hospital.

DR. KENDIG: The Boston Floating Hospital [for Children].

DR. SWENSON: Yes, and he needed a surgeon there. He asked me if I could suggest somebody, and when I said that I might be available, he said, “The job is open.” I told Melva about this and she said, “You’d better take that job.” Well, I was on a small salary at Children’s because I devoted a lot of time to the ward service. When all of a sudden those monthly checks didn’t appear, I went down and asked at the business office why, and they said, “Oh, Dr. Gross has stopped them.” In 1950, Tufts offered me a fulltime job as associate professor of surgery and chief of surgery at the Floating at a salary that I could manage, and I accepted.

It was a rough time. I liked Children’s, I had a lot of good friends there and they were nice to me; but, they couldn’t help me much. I went to Charlie Janeway for advice about what I should do, but as soon as he heard it that involved Gross he said, “I don’t want to hear another word; don’t ever mention my name.” And I went to Sidney Farber, who was the chief of staff at Children’s and he said, “Well, I’ll try something.” But he never did. I talked it over with Dr. Ladd who said, “Gross can stop appointing you at the medical school and at the hospital any time he wants to. Obviously he hasn’t got anything to fire you for, so he is trying to force you out. You better take the Tufts job it because it’s not going to get better here.”

So I moved to the Boston Floating Hospital. I was sad because we had a good research lab at Children’s. We never lacked money and never had to apply for a grant. We’d just start a project and the money was there. Dr. Ladd somehow always raised the money. So I missed that at the Floating and I missed all my friends. Well, the Floating Hospital, although small was a very nice place to work. Dr. Jim [James] Baty was the head of the department of pediatrics. We had worked together at Children’s, and he was very nice to me at the Floating. I developed quite a service. I finally pulled out of a full time position at Tufts because I was bringing in a lot more money into the hospital than they were paying me. All of a sudden I was in private practice. In two years, I tripled my income. I stayed at the Floating for ten years.
I had a number of chances to move. I got a call from Northwestern University Medical School in Chicago that said that they were looking for a person to replace Dr. Bill [Willis J.] Potts who was retiring. I went to Chicago and the job looked pretty interesting to me; but I didn’t hear from them after my visit. I also had had a chance to go to Rochester and several other places, but the major reason I didn’t want to leave Boston was that I wanted to follow my kids with megacolon that I had operated on and I knew I could follow them very carefully if I stayed in Boston. So we decided we’d build a house and settle in Boston permanently.

We had no more than got our house built when the dean of Northwestern University Medical School called me and said, “We want you to come back and talk to us again about being chief of surgery at the Children’s Memorial Hospital.” When I visited they offered me the job. Well, it was quite exciting because they were going to build a building for research and they were going to give the surgical service one floor.

DR. KENDIG: Just what you were looking for.

DR. SWENSON: Yes, but the salary was 20% less than I was earning. So I said, “Well, I can’t do it” and I went home. Then they called me and said, “Come on back, we’re going to give you a better deal,” and they upped the ante a little bit. Again I said, “No, I’m settled in Boston.” But they said, “You’ve got to talk to the chairman of our children’s hospital Board, Mr. McFee, who is head of one of the big department stores downtown.” He was quite a salesman! In an hour’s conversation; he convinced me and signed me up. And I walked out a little dizzy. I thought, “What’s Melva going to think about me taking a job with less money?” Well she said, “We can do it. We’ve been sending our kids to private school; we won’t send them to private school.” She had it all worked out. So I went to Chicago in 1960.

The Children’s Memorial Hospital Board was a great. One of the first things that I wanted to do was to reorganize anesthesia. It was very peculiar but the Boston hospitals were very slow in accepting MD anesthesiologists. Dr. [Harvey] Cushing had nurse anesthetist who was very good. At Children’s, they only had nurses, that’s all. But when I went to Tufts, I was assigned a physician anesthesiologist who spent all his time on children and was great. In Chicago the head of the anesthesia department lived in Peoria and had a private practice. He came to Children’s Memorial once a week only to do cases for Bill Potts. The rest of us pediatric surgeons were left with nurse anesthetists. When I said I wouldn’t take the job unless this was changed, the Board guaranteed the money to create a full-time, good anesthesia department.

But changes were becoming inevitable. The pediatric surgical subspecialties were beginning to encroach on pediatric general surgeons. For a long time,
pediatric surgeons did almost everything: fractures; urology, chests and hearts. But one thing pediatric surgeons didn’t do was neurosurgery. I got a lot of flak from the private pediatricians. They would send a kid with a head injury into the hospital where he was usually seen by a resident and they didn’t like that. They wanted a more experienced guy. We had a good neurosurgeon, but he was all over town. I told the Board that we had to do something about this and they put up the money to have a full-time pediatric neurosurgery service and we got that going.

It got so that I was doing more urology than I really was interested in and I decided that we needed a pediatric urologist. We only had an adult urologist who came to Children’s Memorial once every few weeks and wasn’t really interested in children. When I went to the Board they said, “Look, we can’t put that much money into it.” So I went to the head of urology at Northwestern and together we scared up some money from the [John A.] Hartford Foundation and to get urology straightened out. When I realized that pediatric ophthalmology was a problem, I went to the university and they again helped me out to get an ophthalmology department all started.

Orthopedics was also a problem but when a bequest came to the surgery department I decided to use it to start full time orthopedics and we did. The bequest included a stipend that I should have used for myself! We recruited a good man, Dr. Mihran O. Tachdjian, from Boston. Dr. Bill [William T.] Green at Boston Children’s called me up and excoriated me for taking Tachdjian away from him.

We had created a very good organization. I think we were the first children’s hospital in the country where we really covered everything surgical. We were able to say, “If you send a child into our emergency room, he’ll be seen by appropriate and experienced people, right off.” You know, I probably lost standing with my general pediatric surgical colleagues because of this. Many were angry that I chose the route of subspecialization. Maybe I was wrong, I don’t know.

DR. KENDIG: You were probably ahead of your time.

DR. SWENSON: Well, it was partly the pressure of pediatricians on me that brought this on.

DR. KENDIG: The pediatricians?

DR. SWENSON: Yes, they’d come into my office and shout that they had admitted a kid with a head injury that hadn’t been seen in 24 hours by a neurosurgeon. We didn’t have any real trouble; we were lucky; but I think this it was the right way to do things.
I really had a nice time in research in Chicago. At that time the NIH [National Institutes of Health] was expanding and you could get money for the damnedest things. I had a bunch of projects going and I hired a full-time chemist to help us because we were interested in what was going on in the rejection of kidneys. I got an electron microscope.

DR. KENDIG: Wow!

DR. SWENSON: We brought in some people from one of the training centers in Washington who we supported under NIH grants. I had some other people working full-time, because I had plenty of research money. Then, bang, the whole damn thing went bust when, as you know, the NIH just about closed down. The Hartford Foundation had been very good to me, but they were in trouble because of the market collapse, so I lost that support also. It was very sad to have to let these people go. In my last few years at Children’s Memorial during the 1970s there was a load of trouble with strikes and sit-ins and I about had it up to here. It seems as though things were beyond anything that I could do. I was really anxious to retire but I still had some projects that I wanted to finish.

I called friends at the University of Miami and I completed some of my work down there between 1974 and 1980. I did work in correcting extrophy of the bladder, which is a terrible defect. I’ve done about 150 surgeries for this condition.

DR. KENDIG: Really?

DR. SWENSON: The major problem was their incontinence and I was determined to try to help these kids. So we worked on an artificial sphincter with Codman & Shurtleff [Inc.]. They had good engineers and we actually had a device that worked. We put one in a kid and it worked; but the thing failed after a year. When I was about to retire, Codman & Shurtleff had a change of management. Their new CEO heard about this failure, and he says, “Oh, we don’t want to be involved any longer.”

Dr. Mark Rowe was head of pediatric surgery at the University of Miami, and he was very nice. I worked in a beautiful lab where I was given space. We really pushed the artificial sphincter, but no one has picked it up since.

DR. KENDIG: Talk about some of your other research projects over the years.

DR. SWENSON: You know, there’s a lot of discussion about the fluid requirements of the post-operative patient. When I started, you couldn’t give fluid intravenously because children often had terrible fevers.
afterwards. So everyone was giving fluid by clysis, which was terrible, you know.

DR. KENDIG: Yes.

DR. SWENSON: The fever problem was solved at the Brigham by Carl Walter. They had a lot of trouble with fevers and do you know why? The infusion tubes were made of glass and reused and remnants of blood remained in the system—they just weren’t that clean. That’s why they started using disposable supplies made of plastic. If you used a new set every time, the whole fever problem was solved. Well, there was a great enthusiasm for fluids. When I was a house officer in pathology doing autopsies at the Children’s [Hospital Boston], Dr. Farber would say, “This kid was fluided to death. Everything is full of fluids. They’re giving too much fluid.” I was convinced, but I thought we ought to try to really nail this down. Now, what we did was not really that scientific, but it’s the best we could do. There was a scale available to weigh patients that was very, very sensitive. We hooked the scale up to a flow meter that would only let fluid go in if the patient’s weight fell, so we could keep the patient’s weight at a constant level. And it turned out that we were often giving too much fluid. That was one of my favorite experiences.

I was also interested in megaloureters, which are still an unsolved problem. I had a doctor, Dr. [Luis] Grana, working on that. He had the idea that it might be caused by chronic infection. We mixed up a juicy batter of bacteria in a plastic bag and buried it in the abdomen of a dog. We connected this to the renal pelvis of the animal and started a slow drip of bacteria. Not surprisingly the dogs got a kidney infection, and by gosh, we were able to show that chronic infection produced a megaloureter. Unfortunately no one has ever followed up on this.

I’ve taken lot of flak, because I wondered about the enervation of the ureter. Now the ureter doesn’t have the elaborate system of the intestine. It has a very simple system that has some control from ganglion cells in the base of the bladder. Sidney Farber had about ten specimens of the whole urinary system taken out at the autopsies of megaloureter patients. We made sections of the bladder and we showed that there were practically no ganglion cells. But since they were only decreased but not absent, it was not a clear-cut yes or no, and conclusions were not definitive. [Simeon Burt] Wolbach, who’s a professor of pathology, went through all of our material before we published it, and agreed that there absolutely was a difference—a decrease in the number of ganglion cells—but not all or none. I took a lot of flak, particularly from people in England, about this.

Just before I retired I decided to do a complete follow up on about 400 patients with Hirschsprung’s disease that I had seen. Obviously we couldn’t
ask all of these people to come back to Boston—they were from all over the country, but there were medical meetings in various places. If there was a meeting in New Orleans, our secretaries would get the names of all the patients in that area and send them a notice saying I would be in at the hotel and asked them to please come and see me. God, they turned up! So I had an opportunity to really see how they were really doing—and most of them were doing well. Until we published that, no one would believe us.

DR. KENDIG: Great long-term follow up.

DR. SWENSON: The group at [University of] Michigan, [Arnold G.] Coran and his group, had said, “Look, Swenson’s operation is no good because it disturbs sexual function.” [Franco] Soave, an Italian surgeon had suggested another approach in which he peeled the mucosa from the aganglionic segment and pulled the bowel through that. His argument was, this would not damage structures and affect sexual function. But we were able to describe 90 patients who were married, and among them they had a total of 146 children.

DR. KENDIG: Great testimony.

DR. SWENSON: It’s one thing to say they didn’t have trouble, but the real facts proved it. Do you know about the Great Ormond Street Hospital [for Children] in London? It’s a famous children’s hospital.

DR. KENDIG: Yes indeed.

DR. SWENSON: They were very interested in sexual function after surgery for megacolon. The first consultants that did cases there used blunt dissections rather than the careful dissection we suggested. These kids had a defect. They could get an erection and climax, but they couldn’t ejaculate. Denis Browne, who had become chief of surgery at Great Ormond Street, sent a young registrar over to us in Boston to see how we were doing the surgery. He went back and said, “We’ve got to use sharp dissection.” So they started doing that. When Harold [H.] Nixon in Great Ormond Street looked up all of their patients, he found that their patients done very early had a lot of trouble. But when Nixon got a hold of 85 patients with a 26-year follow up, they were doing well. They had 60 patients that were married, and they had a bunch of children. So, that was pretty good evidence.

Then my associate, Joe [Joseph O.] Sherman, at Children’s Memorial was a computer expert. He said, “Look, you guys have just fiddled around with computers and statistics. Let’s do a 40-year follow up study and really do it right.” So he spent two or three years on the project. He took his paper up to the statistics department at the University of Michigan. They went over
everything and said, “We can’t find fault with your statistics at all.” So we felt pretty good about that.

DR. KENDIG: Yes indeed.

DR. SWENSON: Joe submitted this paper to the *Journal of Pediatric Surgery* and they turned it down. I can’t explain why. They said that there were more interesting papers. One of these “more interesting papers” was a case report of a single patient with Tetralogy of Fallot. Joe was devastated, and I felt for him because I had worked on it too. But we resubmitted it and wiser heads accepted it and published it.

DR. KENDIG: Great.

DR. SWENSON: Well, you know, when I retired, some responsible people had been saying, “Well, Swenson, there are modifications of megacolon surgery that are just as good as or better than your operation.” To study this we went to Pittsburgh Children’s Hospital, where Bill [William K.] Sieber was doing a lot of megacolon surgery using the modification described by a French surgeon named [Bernard] Duhamel. We offered to give them our whole computer program and help them to gather the same kind of data that we had on our patients so we could do a comparison. That would have been a wonderful thing, because he had a big series, but Bill refused. Well, think that I know why. I was invited Pittsburgh to give a lecture. I knew Bill; he’s a nice guy and I wanted to talk to him. I asked his resident, “I haven’t seen Bill. Where is he?” He said, “Oh don’t talk to Bill now; he is in despair” He said three patients had come back with great big fecalomas in the rectal pouch that he’d left in and the kids couldn’t void. And he never reported that in the literature. That’s wrong; that’s absolutely wrong.

Well, anyway, when I finally retired, I figured well, goodbye. I decided to accept that their patients were doing all right. I doubted it, but I said, “All right.”

But about three or four years ago, I sold my boat. I had turned 90 and I damn near drowned myself. So, Melva said, “You’ve got to get rid of it.” So I had a lot of time on my hands, and I got a computer, and fooled around with it. I thought, “Why not do a review article? It has been 50 years; let’s see what has happened.” And so I set the computer going, and you know, it’s a wonder. I entered Hirschsprung’s Disease, and asked for all of the publications under that title over the last 50 years. Well, the machine never seemed to stop and finally coughed out 2000 titles. I had a lot of fun, because I could bring up papers and get the abstracts on most of them. If the abstract didn’t have enough information or wasn’t interesting, I’d throw it away. I then make a list and Melva and I would go to the medical library
and make reprints. God, I had reprints all over the place! I managed to read most of them and I was shocked at some of the things that were being reported. Really. So, I wrote it up and, who’s the editor of Pediatrics?

DR. KENDIG: Dr. Jerry [Jerold] Lucey in Vermont.

DR. SWENSON: Yes, well Lucey is a great guy. He’s a fair-minded guy. And I called him up and said, “Would you be interested in a long review article on Hirschsprung’s Disease?” And he said, “Yes, I think it’s time for one of those.”

But you know I hadn’t written a paper for a long time, and I organized it chronologically, and the reviewers said, “Look, this is a hodgepodge. It’s got to be reorganized.” Well, the review committee included a man who was then the chief of surgery at Boston Children’s Hospital, a nice guy. He said, “This is interesting. I will help reorganize the paper with Swenson,” and so he did. He pounded it into good shape and it was published in Pediatrics in 2002.

DR. KENDIG: It’s a wonderful article.

DR. SWENSON: Well, I tried it to be as fair as I could. Now I’ve got two other papers in the computer that I’m working on. Trouble is, at my age you get tired. I can only work in my shop for two or three hours and I’m tired. But in the afternoon I can work on the computer and I have a lot of fun writing these papers.

I wrote a short one about “recurrences” of Hirschsprung’s disease that were being reported in the literature. Well, we had catalogued almost a thousand cases and I didn’t recall any recurrences like that. What’s going on? Well, I then remembered, when I was Tracy Cabot Fellow, [Walter Bradford] Cannon, the great physiologist retired. At Harvard at that time, he couldn’t stay in the physiology department but had to move to another department, so he wouldn’t interfere. He was very kindly inclined towards the surgeons, so he elected to come to my surgical research lab at Children’s where I got to know him. Later on, when I was working on Hirschsprung’s, I went to Cannon and said, “Look I don’t know how to do it, but we’ve got to find a way to kill the ganglion cells in the segment of gut and see what happens.” I said, “Possibly we could do it by cutting down the blood supply.” Cannon shook his head, and pulled out a paper that he had published in 1913.

DR. KENDIG: Wow.

DR. SWENSON: His paper had shown that the myenteric plexus was so resistant to anoxia that if you destroyed them you destroyed the whole colonic wall. Well, I had that in the back of my mind when I read reports of
acquired recurrence of disease. I couldn’t stop myself from writing a paper
calling attention to Cannon’s 1913 study. I haven’t heard whether they’re
going to publish it.

DR. KENDIG: I’m sure they will.

DR. SWENSON: But I think the computer is interesting, but don’t
depend on the computer, it only goes back so far.

DR. KENDIG: Yes I always tell my residents and fellows that.

DR. SWENSON: Yes. So that’s why I’m back in the business. They were
very nice to me here at the University of South Carolina. The pediatric
surgical group there was very much against my original operation. But they
had a patient that they’d done a Duhamel on, and it was a complete failure.
They had to do a colostomy and the family kept saying, “Can’t we get rid of
the colostomy?” They asked me down to discuss the case and I said, “What
you’ve done with your operation is to leave the rectum in place and replaced
the back part of it with active, normal colon. When it contracts, that part
stretches and you have destroyed peristalsis. That’s exactly what’s happened
to this kid.” And they said to me, “Well, obviously you should take that all
out. When can we schedule the surgery for you to do?” I said, “No, I
haven’t been in an operating for 25 years. I don’t have insurance, and I’m
not even licensed.” But there was a nice young surgeon there named Andrew
Hebrew who’s an expert with laparoscopy.

DR. KENDIG: Yes.

DR. SWENSON: And he said, “I think I can do it.” I told him that in
adults, and this boy was now a big boy of 15, the male pelvis are narrow,
curved and deep. To get down to the bottom of the pelvis is just hell. But
Hebrew said, “I can get my instruments down there, and I can take it out.”
It took him a long time, eight hours, but he got it done. Then we held our
breath. They then closed the colostomy and the kid’s doing fine. You can’t
say that because you used part of the wall of normal intestine, that you won’t
destroy peristalsis, because you do. The peristaltic wave depends on
complete occlusion of the lumen to send it in one direction. An incomplete
closure just doesn’t have any forward momentum. That’s why so many of
these kids are very constipated. But the surgeons there insisted to me, “Oh,
this is the first trouble we’ve ever had.” But then a little nurse in the
audience came up to me after one of my lectures and said, “Dr. Swenson,
you’re getting good results. What laxatives do you use?” She said, “I have a
terrible time. I’ve got these patients in our clinic, and we have to give them
enemas, and we have to give them Colace. Now, what’s your secret? You
just don’t seem to be having trouble.” We didn’t have any trouble. And you
see, the peristalsis, the patients after surgery are dependent on interadominal
pressure to evacuate the colon. They don’t have any help from the contraction of the rectum, which is very good.

DR. KENDIG: Dr. Swenson, we certainly appreciate your sharing your experiences with the American Academy of Pediatrics. I was wondering if you could, just at the conclusion, tell us a little bit about what you think are the major unsolved problems in pediatric surgery today and what areas would you explore if you were just beginning your career today?

DR. SWENSON: Well, I am very curious about the colonic and intestinal mucosa. And looking into the literature, there is not a great deal of detailed cellular work in this area. Now, the mucosa must be a wonderful thing. It takes water out, keeps out the bugs, takes what it wants in—really it’s a magnificent piece of equipment. I think, if I were going into pediatric surgery today, I would go and get a PhD in microbiology. I don’t think you can do much research of any concern unless you’re really up in this very complicated area. I would spend my time on the colonic mucosa. We don’t understand it. We don’t understand ulcerative colitis, and I don’t think we will, until we know in detail how the whole system works. Now, we know a lot about the heart, and we know a lot about the liver, but I don’t think people have been very interested in the mucosa.

Another area I would like to be able to study is the liver and what happens to patients that are born with biliary atresia. You can’t understand this using gross methods. You’re going to have to go to the cellular level. I notice in the surgical meetings now that there are a lot of PhD surgeons that are doing good research. There’s no reason why a person in surgery or medicine shouldn’t get a PhD. I don’t think a fellow can get very far in medical research today, unless he has special training in physiology. Today there are more chairmen of pediatric surgical departments, like the one at Boston Children’s, who have advanced degrees or advanced research training experience. Today, I would go for a medical school that has a combined MD/PhD Program like the one at the University of Miami. I think this would be a must for someone going into academic surgery.

Well, as I’ve already noted, I think a man going into academic surgery has to have additional training either in physiology or in microbiology and included in that should be training in statistical analysis. You know, people laugh at some of the surgical literature. When somebody does five cases and reports good results it’s not statistically worth while. You couldn’t get a meaningful p-value out of it.

Now, another thing that’s got to change is the belief that surgeons make a lot of money, so, let’s not worry about them. At Northwestern in Chicago, we didn’t have any endowed chairs in surgery. When someone gave money to the school to endow two chairs, I put up a very unpopular request, that one
of those should go to surgery. This has got to change, if you’re going to have people doing research in surgery, and it’s coming. Another thing we already talked about is that the surgeon is expected to make his salary through practice, and still do research and that often doesn’t work out. I think medical schools and hospitals need to have a full-time setup where the surgeon isn’t totally dependent on patient care. At Chicago, we were given a salary. We could make 20% more, but after that any clinical income went into the department and medical school till. I thought that this was a pretty good system. I don’t know how to pay doctors and financial disputes breakup departments. What’s your experience with salaries? Do you have a lot of full-time surgeons?

DR. KENDIG: We’re all full-time at [Penn State Milton S.] Hershey [Medical Center], and some people have more research time and some people have less research time, depending on their grants. If you can pull in grants, then you can be excused from some of the clinical time.

DR. SWENSON: Yes. Well, you’ve got to give some freedom to people in surgery. If you get a fellow that’s interested in investigative work, grab him, because there aren’t very many of them. I don’t know. I think the whole medical profession should be full-time. I think the fee for services works, but I think it has its shortcomings. You look at the patient; how much can I get out of him? Well, I don’t think like that possible attitude at all. In the hospitals where I worked, Boston Children’s, the Floating and Chicago, I controlled my fees. If I talked to a family that didn’t have insurance and was short of money, I said, “Look, there’ll be no professional fee,” and I sent them to social service to get help in paying the hospital bill. I must say, I never had one of my patients turned down. Somehow or other, in all the three institutions, they found a way to take care of them. We never turned away a patient, and that’s the way it should be.

I think the greatest blotch on American medicine is that we have a huge population without medical insurance. What’s the use of educating young people if you don’t take care of their health? There is no sense in it. First of all you should take care of their health, then they do better in education; but, we’ve got it backwards. Well, it’s helpful the way it is, but it could be a lot better. I know; I dare not speak my opinion around here in Charleston, because it’s solid Republican. I’m sure that I’d lose all my friends if I expressed my view on medical care. It’s amazing. They all think, “Oh, we don’t want the government to meddle with our practice.” I have talked to some of them and asked them, “How’s Medicare?” And they answer, “Oh, it’s great.” Well, of course it’s great. The only thing is how to expand it. We’ve got the money and if we would give up building one big aircraft carrier, it would solve most of the financial problem for health care.

DR. KENDIG: In a big hurry.
DR. SWENSON: I was invited to Japan by some people from there that I had trained. I was afraid to talk about the war, because I thought it would be a sensitive subject. But somehow the war came up when I was talking to a young fellow who was our guide and he said, “Oh, this was a happy war.” And I said, “God, what was so happy about it?” He said, “It destroyed the military class in Japan and we can have peace now.” He said, “With the money to build a big fighter airplane, we can educate a whole bunch of kids.” Now, that’s the proper attitude.

DR. KENDIG: Dr. Swenson, I wanted to ask you if you ever had a chance to research anything regarding the life and times of the Dr. Hirschprung?

DR. SWENSON: Well, not really. I had a young fellow come visit us from Denmark. He was a pediatric surgeon, and he invited me to visit with him when I came to Copenhagen, Denmark. We were invited to his apartment, and when I met his wife for the first time, and he whispered, “She’s the granddaughter of Harald Hirschprung.” She had a room full of artifacts from Harald’s work and his papers and she was very interesting to talk to.

The Hirschprung family was a very wealthy family. They made cigars, and Hirschprung cigars were the best you could get in Denmark. Harald was the only child that didn’t go into the family business. He went to medical school and became the famous fellow that we hear about today. He wrote his original paper about megacolon paper in 1888. I don’t think the young lady had ever met him, but she had a lot of dope about him. I thought that she could be a source of historical information about Hirschprung, but sadly her husband disappeared. One day he just didn’t come home from work. No one ever found out whether he was abducted or what, but she felt that he was alive somewhere. This severed my connections with her, so I’ve never followed it up. If someone could find her in Copenhagen I’m sure she could give a lot of information. But that’s as far as I’ve gone.

DR. KENDIG: Dr. Swenson, I also wanted to ask, having lived in Independence, Missouri for quite a while, did you ever get to meet Harry [S.] Truman?

DR. SWENSON: Oh, yes. When I was young everybody there knew Harry Truman. He was a local politician. He was a county commissioner. They called him Judge, but he really ran the business of Jackson County, which included Independence and Kansas City.

He didn’t mince words. I remember when they were talking about building a new government office in Kansas City and they had a lot of local architectural offers. Truman said, “I won’t have chicken coop architecture.”
And so he took his old car and traveled all over the country at his own expense to find a good architect. He chose a traditional architect and they built a very nice building. But that’s the sort of a guy he was; he didn’t give up easy.

He was quite an interesting fellow. He courted his wife for years, you know. Now, his family was originally from the Charleston, South Carolina area. They were genuine Americans from way back. Some Boston people can claim descendants way back to the first settlers, and he could do the same. The only difference was his family was very poor. The family had a little farm and he ran it for a while and worked awfully hard. His father was a handyman and did road maintenance. Once tried to pick up a great big stone, and was so determined to move it that something went wrong with his heart and he fell dead. But that was the kind of people he came from. Harry Truman was very determined.

He never went to college, you know. A high school education was all he had. But he read practically every book in the little library in Independence, and he knew Greek. Once, when one of the judges on the [US] Supreme Court cited some Greek reference that was wrong, Truman called him to correct him. I can tell you this; he was an honest man. When he left office in Washington he didn’t have enough money to ship all his stuff home. So he went to his Secretary of State, Dean Acheson, a very wealthy man, and Dean lent him $10,000.00. Well, a funny thing. Dean Acheson’s daughter married into a very wealthy family in Detroit and her husband had Hirschsprung’s disease. He had a heck of a life, and he’d had various operations and when he was about 45, his doctors heard about us. He came to Boston and, no question, he had the disease. You know, I hated to do adults who are very difficult because of the large size of the pelvis compared to a baby. Well, we resected him and he got a leak and got infected. He was very sick; I thought we were going to lose him but we got him through it, and he did all right. He was slated to be president of the American Natural Gas Corporation, but he was given streptomycin to treat his postoperative infection and lost a lot of his hearing. He couldn’t go on in the business, and so he took an early retirement. But I asked his wife, if this story of about the loan to Truman was right and she said, “Yes, my father, Dean Acheson talked about that more than once.” So I think that’s a true story.

DR. KENDIG: Well, that’s a fascinating story.

DR. SWENSON: Truman, you know, wrote his own memoirs when he was eighty-something years old, and he was getting a little fuzzy. He told about traveling across the Pacific to discharge General [Douglas] MacArthur, and he said, “You know, when two officers in planes approach a landing field at the same time, the junior officer has to land first to be sure everything’s all right before the senior goes in.” Truman said, “We circled
for two hours waiting for MacArthur.” It probably isn’t a true story. [David] McCullough, in his book, debunks it and said that actually MacArthur landed first and even had a new hat. That was Truman’s imagination, but it made a damn good story.

I’ll tell you another thing, he courted Bess for a long time and her family had money. They were getting close to marrying, when her father committed suicide. As the oldest girl she kind of took care of the family. She had her hands full and didn’t think she ought to get married, but they saw each other for five or six years. Harry didn’t have any money and so on Sundays they’d go for a long walks. Now, you remember that first lady, Mrs. Truman was a prim and proper lady who was a bit on the dumpy side.

DR. KENDIG: Yes.

DR. SWENSON: She was a good tennis player and in high school she played baseball. She played the third base because she had the best arm to throw the ball to first. I’m not sure whether the story is true, but Truman said that one day as they were walking home they passed where her baseball team was playing and losing. Bess said, “I better get in this game.” They substituted her into third base, she hit a home run and her team won. She was an athletic person; you wouldn’t think that from what you saw of her as the first lady.

If you have a chance, visit Truman’s home. It’s now open, and when you go into the kitchen, it has an old linoleum rug that in places is worn out. Truman put tacks all around it that, so people wouldn’t trip. It’s right there. You can see it. He was quite a character.

DR. KENDIG: Well Dr. Swenson, on behalf of the American Academy of Pediatrics and the Section on Surgery, I’d like to thank you for this interview and congratulate you on your most distinguished career in the field of pediatric surgery and thank you for your memories, insights and advice.

DR. SWENSON: Well, it’s been fun.

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CURRICULUM VITAE

ORVAR SWENSON, M.D.

PLACE AND DATE OF BIRTH:

Helsingborg, Sweden February 7, 1909

MARRIED:

Melva Criley, 1941
Three Children: Wenda, Elsa, Melva

EDUCATIONAL BACKGROUND:

B.A. William Jewell College Liberty, Missouri, 1933

M.D. Harvard Medical School Boston, Massachusetts, 1937

Le Titre De Docteur Honoria Causa De
L'Universite D'Aix, Marseille, France, 1975

Doctor of Science, William Jewell College, 1986

HOSPITAL TRAINING FOLLOWING GRADUATION:

Surgical Intern
Ohio State University Hospital Columbus, Ohio
July 1937- June 1938

House Officer in Pathology
Children's Hospital Boston, Massachusetts
July 1938- April 1939

Surgical House Officer
Combined Peter Bent Brigham Hospital and
Children's Hospital Service
Boston, Massachusetts
May 1939- September 1941

Assistant Resident surgeon
Peter Bent Brigham Hospital Boston, Massachusetts
October 1941- September 1942

Arthur Tracy Cabot Fellow
Harvard Medical School Boston, Massachusetts
November 1941- June 1944

Resident Surgeon
Peter Bent Brigham Hospital Boston, Massachusetts
February 1944- February 1945
ACADEMIC APPOINTMENTS:

Assistant in Surgery
Harvard Medical School
Boston, Massachusetts
July 1942 - July 1944

Instructor in Surgery
Harvard Medical School
Boston, Massachusetts
February 1944 - June 1947

Associate in Surgery
Harvard Medical School
Boston, Massachusetts
July 1947 - October 1950

Lecturer in Surgery
Simmons College
Boston, Massachusetts
July 1948 - 1950

Associate Professor in Surgery
Tufts University School of Medicine
Boston, Massachusetts
1950 - 1957

Clinical Professor of Pediatric Surgery
Tufts University School of Medicine
Boston, Massachusetts
September 1957 - August 1960

Professor of Pediatric Surgery
Tufts University School of Medicine
Boston, Massachusetts
October 1957 - August 1960

Professor of Surgery
Northwestern University
School of Medicine
Chicago, Illinois
October 1960 - June 1973

Professor of Surgery
University of Miami School of Medicine
Division of Pediatric Surgery
Miami, Florida
1974 - 1980

HOSPITAL AFFILIATIONS:

Junior Associate in Surgery
Peter Bent Brigham Hospital
Boston, Massachusetts
May 1945 - 1950

Junior Attending Surgeon
Children’s Hospital
Boston, Massachusetts
July 1945 - June 1947
Surgeon
Children's Hospital
Boston, Massachusetts
July 1947 - October 1950

Surgeon-in-Chief
Boston Floating Hospital
Boston, Massachusetts
October 1950 - September 1960

Surgeon-in-Chief
Children's Memorial Hospital
Chicago, Illinois
October 1960 - June 1973

Consultant in Surgery
Great Lakes Naval Hospital
Chicago, Illinois
1967 - 1968

Surgeon
University of Miami
Jackson Memorial Hospital
Miami, Florida
1973 - 1979

MEMBERSHIPS:
American Academy of Pediatrics,
Surgical Fellow
American Association of Thoracic Surgery
American Board of Surgery
American College of Surgeons, Fellow
American Medical Association
American Pediatric Surgical Association
American Surgical Association
American Thoracic Association
American Urological Association,
N. E. Section
Asian Association of Pediatric Surgeons,
Honorary Member
Boston Surgical Society
British Association of Pediatric Surgeons, Honorary Member
Canadian College of Physicians & Surgeons, Honorary Member
Greek Association of Pediatric Surgeons,
Honorary Member
Italian Association of Pediatric Surgeons, Honorary Member
Massachusetts Medical Society
New England Pediatric Society
New England Surgical Society
Pacific Association of Pediatric Surgeons
Society of University Surgeons
AWARDS AND HONORS:

Discoverer of Cause and Cure of Hirschspring's Disease, 1948

Frank Billings Award for Scientific Exhibits: "New Concepts of the Etiology, Diagnosis and Treatment of Congenital Megacolon (Hirschspring's Disease)", 1949

Invited to present work on the discovery of the cause and successful treatment of congenital megacolon (Hirschspring's Disease), Society for Pediatric Research, 1949.

The E. Meade Johnson Award - American Academy of Pediatrics: "Elucidation of the Pathogenesis and Treatment of Congenital Megacolon", 1952


Cobb-Pilser Lecture - Vanderbilt University Medical School, Nashville, Tennessee, 1957

Blackfan Lecture, Harvard University, Children's Hospital, Boston, Massachusetts, 1958

Annual Award for Outstanding Contribution to Urology - Buffalo Urological Society, 1959

Felton Bequest Visiting Professor of Surgery, University of Melbourne, Australia, 1959

Member of the editorial Board, Pediatrics, 1962-1969.

Special Guest Lecturer, the 16th General Assembly of the Japan Medical Congress, Osaka, Japan. "Physiologic Defects of the Genitourinary System", 1963

George B. Packard, Jr., Lecture, University of Colorado, Denver, Colorado. "Surgical Correction of Anomalies of the Colon and Rectum", 1964

Visiting Professor, University of Hawaii, Honolulu, Hawaii, February and March, 1968

Honorary Fellow, Royal College of Surgeons, Dublin, Ireland, 1969

Ladd Award - American Academy of Pediatrics, Surgical Section, October, 1969

McCluskey Lecture - University of Pittsburgh School of Medicine, May 1970
Visiting Professor, Dalhousie University, Halifax, Nova Scotia, Canada, November 1970

Achievement Award. Modern Medicine, 1971

President, American Pediatric Surgical Association, 1973

Advisory Panel, Neurological and Gastrointestinal Devices, Food and Drug Administration, 1973 - 1975

Visiting Professor, John's Hopkins School of Medicine, 1974.

Robert Garrett Visiting Professor, John's Hopkins University School of Medicine, 1975

Denis Browne Gold Medal, British Association of Pediatric Surgeons, for Discovery of Cause and Cure of Hirschsprung's Disease, 1979

Made Honorary Fellow of Canadian College of Physicians and Surgeons, 1980

Visiting Professor - University of Bombay, Bombay, India, 1980

Made Honorary Fellow - Greek Association of Pediatric Surgeons, 1985

Made Honorary Fellow - Italian Association of Pediatric Surgeons, 1985

Swenson Visiting Professorship established in his honor, Tufts University School of Medicine, 1987.

Swenson Chair in Pediatric Surgery established at Tufts University School of Medicine, 1990.

ORVAR SWENSON, M.D.

PUBLICATIONS


Swenson, O., and Rheinlander, H. F.: Indicaciones para la colostomia en pacientes con enfermedad de Hirschsprung (De "El Dia Medico") XXV, No. 14, 1953.


